For Employees and Retirees covered by the
Duluth Joint Powers Enterprise Trust Health Plan 3A

Outpatient Prescription Drug Benefit

A Summary Overview

Effective January 1 – December 31, 2015

Claims Administrator: ClearScript℠

Your Duluth JPE Trust
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Prescription Drug Plan Design

A Formulary is a list of drugs that have been approved for use and are available through the outpatient prescription drug benefit plan. All prescription drugs on the Formulary are assigned to a tier (i.e., first tier generics, second tier preferred brands, and third tier non-preferred brands). Your co-payment and/or co-insurance are determined by the tier to which the prescription drug has been assigned. The plan covers outpatient prescription drugs at participating pharmacies. When you present your ClearScript Prescription Drug Identification (ID) Card or otherwise provide notice of coverage at the time of purchase, you pay only the prescription drug co-pay. If you do not present your ClearScript ID Card or otherwise provide notice of coverage at the time of purchase, you will be charged the full amount of the prescription drug.

Prescription Drug Benefits*

Tier	Description	Retail Co-Pay Amount
First	Generic Drugs	**$0**
Second	Preferred Brand Name Medications	**$15**
Third	Non-Preferred Brand Name Medications	**30% co-insurance ($30 min/$100 max)**

Medication Therapy Management (MTM) program available

*Deductibles and out-of-pocket maximums do not apply to outpatient prescription drug benefits.

Identification (ID) Card

Present your ClearScript Prescription Drug ID Card to a participating pharmacy when you order a new or refill prescription. You may use this card at any participating pharmacy. With the Argus Network, you can get your prescription filled at any of the more than 63,000 participating pharmacies located nationwide. The network includes major chains, as well as independent pharmacies. If you would like to locate the closest participating pharmacy, call ClearScript at 1-855-816-6389 or log on to the ClearScript website at www.clearscript.org/duluth. If your ClearScript ID Card was lost and you need a replacement card, simply call 1-855-816-6389 to request an ID card.

Accessing Information Anytime

Internet

- Go to www.clearscript.org/duluth
- Select "Member Log-In" under the picture on the right
- Click on 2015 Member Login
- First-time users should follow the instruction on the page to create an account using the Create New Account option
- **Note:** a separate username and password is required for each member of a household. Multiple accounts cannot be viewed from a single login.
- To create a new account you will need your member card information
- After your account has been created, remember your User ID and password, as these are needed to login
- The Member Access application will open another browser window after you successfully login
- If you use a Pop-up Blocker, please either turn it off or include www.argushealth.com in your setting for allowed sites

The following information is available online:

- Claim History – This area allows you to view your prescription history
- Preferred Drug Search – This links you to the NPS formulary. This tool will help you determine which copayment applies to your prescription (i.e., brand/generic, formulary/non-formulary)

Important Telephone Numbers

Customer Service is available 24 hours a day, 7 days a week, at 1-855-816-6389

- Order replacement ID Cards
- Request claim forms
- Receive assistance in locating a participating NPS network pharmacy
- Speak with a member services representative for assistance

Important Drug Protocol Initiatives

In an effort to support and provide members with the best medical care at a reasonable cost, the following programs have been implemented: **Step Therapy Program**, **Over-the-Counter (OTC) Drug Program**, and **Tablet Splitting Program**. In addition to these programs, all Prior Authorizations for Duluth JPE Trust health plan members must strictly adhere to the clinical guidelines and Prior Authorization criteria established by ClearScript.

Prior Authorization (PA) Process

To promote appropriate utilization, selected high-risk or high-cost medications may require PA to be eligible for coverage under the member's prescription drug benefit. PAs are only issued to a member in cases of:

1.) Documented prior failures on Formulary or Preferred Agents (as defined by current evidence-based clinical guidelines and appropriate medical review with adequate trial periods).
2.) Medical necessity – As defined as a prescription medication which is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, the current Preferred or Formulary alternatives are not acceptable to current peer-reviewed medical literature, and which meets the following conditions: a.) it is recognized throughout the medical profession as safe and effective; b.) it is employed appropriately in a manner and setting consistent with generally accepted United States medical standards; and c.) it is not experimental in nature.
3.) Off-label use of medication – PAs for unlabeled uses of medications may be granted provided that: a.) the medication is approved by the FDA; and b.) two or more peer-reviewed professional medical journals have recognized, based on scientific medical criteria, the safety and effectiveness of the medication or combination of medications, for treatment of the indication for which the medication has been prescribed unless two articles from major peer-reviewed professional medical journals have concluded, based on scientific or medical criteria, that the drug or combination of drugs is unsafe or ineffective or the safety and ineffectiveness of the drug or combination of drugs cannot be determined for the treatment of the indication for which the drug or combination of drugs has been prescribed.
4.) Overriding an existing quantity limitation provided a specific dosing and tapering schedule is presented.

PA requests will not be approved for members requesting an exemption from the highest co-payment to the middle co-payment unless the above stated criteria are appropriately documented. In most cases, PA requests will be approved for one year from the date the request is received in the NPS office; however, certain exceptions and exclusions apply. PA forms may be obtained from your benefits coordinator or by calling ClearScript at 1-866-718-2845, press option 2. PA request forms must be completed in-full prior to evaluation of your request.

When and How to Submit a Prescription Claim Form

If the pharmacy did not submit your request for outpatient prescription(s) payment to ClearScript at the time of fill and less than two weeks have passed, you should return to the pharmacy with your receipt and ask that they attempt to submit the prescription(s) for funding from ClearScript. Once the prescription(s) have been submitted, you should receive your refund from the pharmacy. If your request for service has gone longer than two weeks*, please follow the instructions below:

1.) Complete, sign and date the enclosed "Direct Reimbursement Claim – ClearScript";
2.) Include all the original outpatient prescription drug receipts; and
3.) Mail to:

Argus Health Systems
Dept: 0681
PO Box 419019
Kansas City, MO 64141

* ***Your prescription claim requests must be submitted for review within 90 days of the date services were rendered***. This request must include the original pharmacy receipts, and the claim form must be completed in its entirety to avoid delays in processing your request. NO PHOTOCOPIES of pharmacy receipts are accepted. Do not send cancelled checks or cash register receipts. The Argus network consists of pharmacies located in the United States; therefore, no International claims will be processed. The form must be completed each time a claim is submitted to Argus.

Specialty Drug Program Information

All outpatient prescription drugs in the "Specialty" class will be filled through an exclusive specialty drug provider, Fairview Specialty Pharmacy. Specialty pharmacy programs are designed specifically for patients with complex or ongoing conditions. By using Fairview Specialty Pharmacy, members will enjoy the convenience of having their drugs delivered to their home, safely and on time**. Effective January 1, 2013, specialty drugs will require a prior authorization (see page 3, *Prior Authorization Process*).** To obtain a list of specialty drugs, to transfer your prescription(s), or to obtain additional information, please call 1-800-595-7140.

Diabetes Management

Effective January 1, 2015 Abbott Diabetes Care is no longer the exclusive provider of blood glucose meters and test strips.

Any other diabetes blood glucose monitors and test strips will be available on the formulary without a prior authorization. If you have further questions, do not hesitate to contact the Customer Service Center toll free at 855-816-6389.

Medication Therapy Management (MTM) Program

MTM services encompass the assessment and evaluation of a member's complete medication therapy regimen, rather than focusing on an individual medication product. The goal of the MTM program is to improve the member's health and reduce medication therapy problems by providing an individualized patient care plan. A pharmacist will work with individuals and their health care providers to better understand the individuals' medication history and current health status. Once the pharmacist has gathered all the medical information, the goal is to assist the member in managing medications and reduce the risk of complications. The pharmacist can also provide members with dietary, lifestyle and smoking cessation information. MTM services may: 1.) contribute to medication error prevention by enhancing a member's understanding of appropriate drug use; 2.) result in improved reliability of health care delivery; and 3.) enable patients to take an active role in medication and health care self-management.

MTM is available to members covered under the Duluth JPE Trust's hospital and medical benefit plan who:

- Use four or more program-specified maintenance medications; OR
- Have diabetes; OR
- Are diagnosed with at least two (2) of the following chronic conditions: high blood pressure, high cholesterol, asthma, chronic pulmonary disease, heart failure, or depression.

Interested participants can meet with the MTM pharmacist either in person at a designated pharmacy or by telephone visits. An appointment will be scheduled for you to meet privately with the pharmacist or conduct your visit by telephone at least once every three (3) months. ***Participants will not be charged for the appointments.*** During the appointments, the pharmacist will talk with participants about:

- Current use of medications (how it is taken, how well it is working, side effects, etc.)
- Treatment goals and the action plan to meet the goals
- Nutrition and exercise
- Participant's knowledge of his/her medical condition(s)

Questions regarding the MTM program should be directed to Fairview Pharmacy Services by email at mtm@fairview.org or by phone at 866-332-3708. Participation in the MTM program is strictly confidential and the City of Duluth will not have access to any information related to any member's participation in the program.

Protecting Your Privacy

Your privacy is important to us. ClearScript and Fairview Pharmacy Services use health and prescription information about you and your dependents to administer your plan. This process generally involves reporting

information to your health plan. To ensure your privacy, we use a sophisticated system to carefully monitor this process and we comply with Federal law, including the HIPAA privacy standards.

Outpatient Pharmacy Coverage Management

To help control costs, your outpatient prescription drug benefit has certain coverage limits. For example, the following exclusions apply:

- Non-FDA approved drugs;
- Drugs dispensed outside the United States;
- Coverage for prescription drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
- Drugs which are prescribed dispensed or intended for use during an inpatient stay;
- Drugs prescribed by a provider not acting within the scope of his/her license;
- Over-the-counter drugs unless otherwise specified;
- Drugs consumed as an inpatient during a hospital or emergency room setting or in a physician's office;
- Medications and/or dosage regimens determined to be experimental, investigational, or unproven;
- Drugs for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or any municipal, state or federal program, whether or not a claim for such benefits is made or payment or benefits are received;
- Prescription drugs for or related to infertility treatments;
- Medication for treatment of: impotence, sexual dysfunction, including, but not limited to erectile dysfunction; enhancement of athletic or intellectual performance; weight management or weight reduction; and impedance of the aging process;
- Prescription drugs used to restore hair growth and growth-stimulating hormones;
- Cosmetic hair products;
- Durable Medical Equipment, prescribed and non-prescribed outpatient supplies, other than the diabetic supplies specifically stated as covered;
- Charges for the administration or injection of any drug;
- Vitamin or dietary supplements;
- Drugs as a replacement for a previously dispensed prescription drug that was lost, stolen, broken or destroyed;
- Prescription drugs not included in the member formulary;
- Selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety or side-effects;
- Drugs used for cosmetic purposes;
- Any manual claim from the member that is received by ClearScript and/or ~~NPS~~ Argus more than 90 days from the date the prescription drug(s) was dispensed to the covered member;
- Drugs dispensed prior to the effective date in the plan or after the member's plan termination date.

Appeal Process

When an insurance plan denies payment for a prescription drug, you have the right to ask that your plan reconsider its decision to deny payment. This is called an appeal. When the plan denies a prior authorization, it is required to notify you within 15 days (or 72 hours for urgent cases) of a denied prior authorization:

- The reason your claim was denied
- Your right to file an internal appeal
- Your right to request an external review if your internal appeal was unsuccessful
- The availability of a Consumer Assistance Program (when your state has one)
- If at least ten percent of the population in your county speaks the same non-English language you are entitled to receive your notices and any customer help in the non-English language.

For urgent care situations, members may file an expedited appeal request if a denial involves a medical condition of the member for which the timeframe for the completion of a standard appeal would seriously jeopardize the life or health of the member, or would jeopardize the member's ability to regain maximum function.

When the plan receives your request to review its own decision/denial, it is called an **internal appeal**. If the plan still denies payment after considering your appeal, you have the right to request an independent review organization decide whether to uphold or overturn the plan's decision. This final check is often referred to as the "**external review."** Your state may have a health care Consumer Assistance Program that can help you file an appeal or request a review. If your state has a Consumer Assistance Program, you can find information on it at www.healthcare.gov/consumerhelp.

When you request an internal appeal, the plan must give you its decision within:

- 72 hours after receiving your request when you're appealing the denial of a claim for urgent care. (If your appeal concerns urgent care, you may be able to have the internal appeal and external review take place at the same time)
- 30 days for denials of non-urgent care you have not yet received
- 60 days for denials of services you have already received

You or someone you name to act for you (your appointed representative) may request an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others may already be authorized under State Law to act for you. You can call customer service at 1-855-816-6389 (24 hours a day, Seven days a week) to learn how to name your appointed representative.

The member, a person acting on behalf of the member, the member's physician, or other healthcare provider has the right to appeal either orally or in writing.

To file an internal appeal:

- Have your doctor complete a Prior Authorization/Redetermination form to request an internal appeal, or you can write to ClearScript with your name and pharmacy plan ID number. In this letter be sure to say you are appealing the plan's denial.
- Submit any additional information that you want the plan to consider, such as a letter from the doctor.

You must file your internal appeal request within 180 days (6 months) of receiving notice that your claim was denied. This should be done in writing, or, when the need for the prescription drug is urgent, over the phone. Your prescriber must provide a statement to support your exception request. You must mail or fax your written request to:

Prior Authorization Appeals
ClearScript
2550 University Ave West, Ste 320N
St. Paul, MN 55114
Fax: 1-855-875-7445
Phone: 1-866-718-2845, Option 2

For denials of care under life threatening conditions, an expedited appeal procedure can be requested. If your situation falls within this category, you or your provider should contact us via phone at 1-866-718-2845, Option 2 .

If your internal appeal request is upheld, you can request an independent review or an **'external review'** of your case by a reviewer outside of your Prescription Drug Plan.

To file an external review, contact the same address as for the Prior Authorization Appeals. The request for an independent (external) review must be made within 60 days of the internal appeal denial. The external review will be conducted by an impartial expert who is not a direct employee of or related to the pharmacy benefit plan, and will provide an independent review of the denied claim. If the independent reviewer overturns the plan's denial, the plan must give you the payments or services you requested in your claim.
Directions for filing an external appeal will vary from state to state.